DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-17

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.40

7. FEDERAL BUDGET IMPACT: See Attachment
a. FFY 2000 $ -0-
b. FFY 2001 $ 2,422,800

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 582 - This amendment establishes procedures for Texas to reward through additional payments those nursing facility providers that achieve superior performance. Providers will qualify to receive additional funds based on demonstrated regulatory compliance and specific performance criteria.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded when received.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 26, 2000

16. RETURN TO:

Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09-27-00

18. DATE APPROVED: November 2, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Andrew A. Fredrickson

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Attachment to HCFA-179 for
Transmittal No. 00-17, Amendment No. 582

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 7	New
Page 7a	New
Page 7b	New
Page 7c	New
Page 7d	New
Page 7e	New
Page 7f	New

VII. Performance-based Add-on Payment Methodology.

(A) Purpose of methodology. Performance-based add-on payments provide additional funding to nursing facilities that meet specific performance criteria.

(B) Funding source. Each fiscal year, the Commissioner of the Texas Health and Human Services Commission (HHSC) will identify the portion, if any, of Medicaid nursing facility service provider funding that will be designated for performance-based add-on payments. This amount is subsequently called the Performance-based Add-on Fund (PAF).

(C) Provider defined. For the purposes of this methodology, a nursing facility provider is a Medicaid long-term care contracted provider licensed and regulated by the Texas Department of Human Services (DHS).

(D) Provider eligibility. To be eligible for performance-based add-on payments, a provider must have had Medicaid-certified beds during the entire service period as defined in subsection (E) of this section.

(E) Service period. The service period for the first year of performance-based add-on payments will begin on September 1, 2000. Each service period will correspond to a state fiscal year that begins September 1 of one year and continues through August 31 of the following year.

(F) Performance criteria. Provider performance will be judged on the basis of compliance with state and federal regulations as well as on the basis of resident outcomes.

(G) Regulatory compliance. Compliance with state and federal regulations is a prerequisite for performance-based add-on payments.

(H) Regulatory compliance accountability period. Each provider's regulatory compliance will be determined as the lowest level of compliance attained on any regulatory visit to that provider during the service period and recorded in the Long-Term Care-Regulatory (LTC-R) data warehouse as of November 30 of the calendar year in which the service period ends. If the service period does not encompass a certification survey to the provider, then the most recently recorded certification visit prior to the service period will be included in the determination of the provider's regulatory compliance.

(I) Levels of regulatory compliance. The levels of regulatory compliance are based on Health Care Financing Administration (HCFA) State Operations Manual, Transmittal 274, June 1995, HCFA-Pub. 7. The following table provides the precise definition for each compliance level.

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Visit Compliance	Definition	Compliance Level	Weight (C)
Total Compliance	No deficiencies.	5 (Highest)	1.00
Substantial Compliance	No deficiency was written at a level higher than the scope and severity levels of A, B, or C as defined by the Health Care Financing Administration in Transmittal 274.	4	0.75
Out of Compliance with No Harm or Jeopardy	No deficiency was written at a level higher than scope and severity levels of D, E, or F as defined by the Health Care Financing Administration Transmittal 274, and no deficiency constituted Substandard Quality of Care.	3	0.50
Out of Compliance with Actual Harm or Jeopardy	A deficiency was written at scope and severity levels G, H, I, J, K or L as defined by the Health Care Financing Administration in Transmittal 274, and did not constitute Substandard Quality of Care.	2	0.00
Substandard Quality of Care	A deficiency was written at scope and severity levels F, H, I, J, K, or L as defined by the Health Care Financing Administration in Transmittal 274, and the deficiency was written in either the Resident Behaviors and Facility Practices, Quality of Care or Quality of Life chapters.	1 (Lowest)	0.00

(J) Resident outcomes. Resident outcomes are determined using a system of Quality Indicators (QIs) whose definitions were designed by the Center for Health Systems

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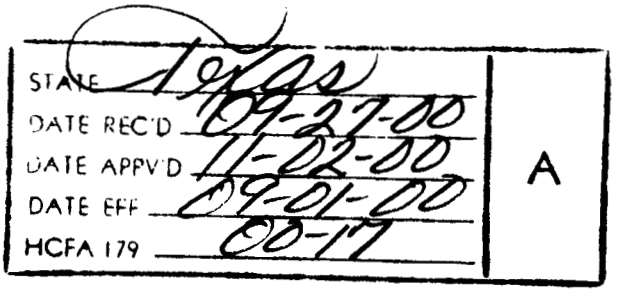
Research and Analysis (CHSRA) under contract to HCFA. These QIs are computed from resident assessment data transmitted directly from the facilities to the HCFA Minimum Data Set (MDS) automation system. The QI automation that will be used in the performance-based add-on system is the DHS implementation already in use for the Quality Reporting System (QRS).

(K) Resident outcomes performance indices. Provider performance with respect to resident outcomes is scored using two indices derived from QI scores. These indices are called the Potential Advantages Score (PAS) and the Potential Disadvantages Score (PDS).

(L) Potential advantages score. The following table provides the definitions for the PAS scale.

PAS	Definition	Weight (A)
Most Advantages	More than four QIs suggest potentially superior performance.	0.500
More Advantages	Three or four QIs suggest potentially superior performance.	0.375
Some Advantages	Two QIs suggest potentially superior performance.	0.250
Fewer Advantages	One QI suggests potentially superior performance.	0.125
Fewest Advantages	No QIs suggests potentially superior performance.	0.0
No Rating	Lack of MDS data for QI processing.	0.0



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(M) Potential disadvantages score. The following table provides the definitions for the PDS scale.

PDS	Definition	Weight (B)
Fewest Disadvantages	No more than one QI suggests potential performance problems.	0.500
Few Disadvantages	Two or three QIs suggest potential performance problems.	0.375
Some Disadvantages	Four or five QIs suggest potential performance problems.	0.250
More Disadvantages	Six or seven QIs suggest potential performance problems.	0.125
Most Disadvantages	Eight or more QIs suggest potential performance problems.	0.0
No Rating	Lack of MDS data for QI processing.	0.0

(N) Determination of PAS and PDS. The PAS index is calculated by counting the number of QIs on which a provider appears at or below the 10th percentile performance threshold. The PDS index is calculated by counting the number of QI conditions on which either a provider appears at or above the 90th percentile performance threshold or on which it has a non-zero numerator for any one of three sentinel event QIs. The sentinel event QIs are dehydration, fecal impaction, and pressure sores in low risk residents. PAS and PDS indices are converted to PAS and PDS ratings using the definitions in the tables in subsection (L) and subsection (M) of this section.

(O) Determination of the 10th and 90th percentile QI performance thresholds.

(1) For defining the 10th and 90th percentile performance thresholds, the QI scale is divided into 100 steps. The PAS threshold is defined as the smallest QI value (in .01 steps) that yields the largest percentile less than or equal to 10%. The PDS threshold is defined as the largest QI value (in .01 steps) that yields the smallest percentile greater than or equal to 90%.

(2) If because of the distribution of QI scores, the 10th percentile performance threshold for a particular QI cannot be determined, then that QI is excluded from

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those that can count toward PAS. Similarly, a QI is excluded from those that can count toward PDS if the 90th percentile threshold cannot be determined.

(3) For the three QIs that HCFA identifies as sentinel events (dehydration, pressure sores in low risk residents, and fecal impaction), a single occurrence counts toward the PDS. Sentinel event QIs have neither a PAS nor PDS threshold.

(P) Resident outcomes performance accountability period. Each provider's Resident Outcomes Performance Indices will be determined from MDS resident assessments with assessment dates during the service period and recorded in the DHS Quality Reporting System's MDS database as of November 30 of the calendar year in which the service period ends.

(Q) Calculation of yearlong quality indicators. QI values are simple quotients consisting of a numerator and a denominator. The numerators and denominators of each provider's QIs will be calculated for each of the four quarters that span the service period. If a lack of provider MDS data prevents QI calculations for any quarter, the provider will become ineligible for performance-based add-on payments. The four numerators for each provider QI will be summed to create a yearlong provider numerator. The four denominators for each provider QI will be summed to create a yearlong provider denominator. The resulting yearlong QI numerators and denominators will be used to determine the 10th and 90th percentile performance thresholds using the methods described in subsection (o) of this section.

(R) Determination of provider performance units. Total Performance Units (TPU) will be calculated for each eligible provider using the formula: Provider TPU = #Medicaid Days x C x (A + B), where "#Medicaid Days" is the number of Medicaid days of service that were provided during the service period, and "A", "B", and "C" are the performance weights as detailed in subsection (L) of this section for PAS, subsection (m) of this section for PDS, and subsection (l) of this section for Regulatory Compliance.

(S) Determination of add-on payment per performance unit. The amount of additional payment for each performance unit (PPU) will be calculated from the formula, PPU = PAF/ (sum of the provider TPU of all eligible facilities).

(T) Determination of provider performance pay. The total amount of performance-based pay due to each provider will be calculated from the formula, Provider Performance Pay = Provider TPU x PPU.

(U) Review of DHS determination.

(1) DHS or its designee notifies nursing facilities of their tentative eligibility for provider performance pay during the service period. Any nursing facility,

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including those nursing facilities that do not qualify or that contend that the amount of payment to be disbursed is incorrect, is allowed to request a review by DHS or its designee. The actual amount of payment also may vary if a successful review request by one or more nursing facilities necessitates an adjustment in the amount of payments to the other nursing facilities in the program. The review must be completed before November 30 after the regulatory compliance accountability period. Because of the state's ongoing review of data elements used in the formulas after DHS or its designee notifies the nursing facilities of their dollar amount reward, it is possible that a nursing facility may either gain or lose eligibility after receiving tentative notification, which would affect payment amounts.

(2) Deficiencies recorded in the Long Term Care-Regulatory (LTC-R) data systems as of November 30 of the calendar year in which the service period ends will be included in the determination of performance weight C. Contested deficiencies pending Informal Dispute Resolution (IDR), but recorded in LTC-R data systems, will be included in the determination of performance weight C. MDS assessment corrections that have not been recorded in the appropriate automation system as of November 30 of the calendar year in which the service period ends will not be considered in the determination of provider performance weights A and B.

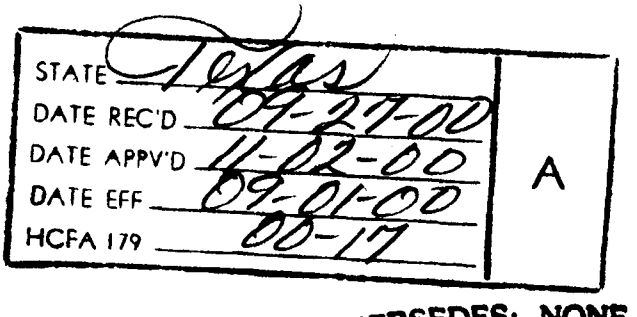
(3) The performance-based add-on payment methodology is designed to disburse the entire performance-based add-on fund. Once the payments are made, no additional review or appeal is available to the nursing facilities.

(a) A nursing facility's written request for a review must be made to the DHS Director of Medical Quality Assurance, Office of Programs, within 10 calendar days after the facility receives notification of its eligibility. Facility performance data are posted on the DHS QRS website, which is updated monthly. Providers have the opportunity to see their performance results on the DHS QRS website during the entire service period. A facility's request for a review must contain specific documentation supporting its contention that factual or calculation errors were made which, if corrected, would result in the facility qualifying for performance-based add-on payment or receiving performance-based add-on payment in a corrected amount.

(b) The review is:

(i) limited to allegations of factual or calculation errors;

(ii) limited to a review of documentation submitted by the nursing facility or used by DHS or its designee in making its original determination; and



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(iii) not conducted as an adversary hearing.

(c) DHS or its designee conducts the review as quickly as possible and makes its decision before disbursing the entire performance-based add-on fund.

(V) Performance-based add-on payment payee. The performance-based add-on will be paid to the provider of record at the time that the payment is made.

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